

**LAC+USC MEDICAL CENTER & HEALTHCARE NETWORK ATTENDING STAFF ASSOCIATION  
DELINEATION OF PRIVILEGES FOR THE DEPARTMENT PEDIATRICS-VIOLENCE INTERVENTIONAL PROGRAM  
NURSE PRACTITIONERS**

NAME OF APPLICANT \_\_\_\_\_ DATE \_\_\_\_\_

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Initial Appointment and/or Additional Privileges

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Reappointment

**Applicant:** Check off only those privileges expected to be performed at the site where you will be working. Note that privileges granted may only be exercised at the site(s) and setting(s) recommended by the Department Chair/Chief/Designee. Shaded areas indicate that the privilege is not applicable for that particular entity.

**Department Chair/Chief/Designee:** Initial the Recommended column for approved privileges. If applicable, check off the “Not Recommended” boxes. Documentation of all privileges must be provided for all privileges on the last page of this form.

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
			Competency	Other
Pediatrics-VIP	<p>Follow department guidelines and standardized procedures, policies and protocols found in the Advance Practice Nursing Policy and Procedures Manual.</p> <p><b>Core Privileges:</b> Basic privileges in Pediatrics/VIP include:</p> <ul style="list-style-type: none"> <li>- Institute treatment essential for the life of the patient (i.e. ACLS),</li> <li>- Transfer patients to observation areas,</li> <li>- Obtain a history,</li> <li>- Perform a physical examination,</li> <li>- Order laboratory and diagnostic procedures,</li> <li>- Interpret laboratory data,</li> <li>- Interpret diagnostic studies,</li> <li>- Obtain informed consent for procedures,</li> <li>- Perform and/or assist in the performance of diagnostic studies within the scope of specialty services,</li> <li>- Perform and/or assist in the performance of therapeutic procedures within the scope of specialty services,</li> <li>- Monitor patients throughout procedure and during recovery period,</li> <li>- Determine assessment and interval for follow up,</li> <li>- Conduct patient and family education,</li> <li>- Manage and provide consultations,</li> <li>- Document patient interactions,</li> <li>- Document care rendered in medical record, and</li> <li>- Complete discharge summaries of patients.</li> </ul> <p>for the following ages:</p>			
	Neonates and Infants from 0 to 2 years of age			
	Children from 3 to 13 years of age			

REQUESTED Pediatrics-VIP	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
			Competency	Other
	Adolescents and Young Adults 14 years of age and older			
	Furnishing of written orders for medications and medical devices.			
	<b>AREA OF SPECIALIZATION</b>			
	1. Violence Interventional Program/Adults			
	2. Violence Interventional Program/Community-Based Assessment and Treatment Center (CATC).			
	<b>SPECIFIC PRIVILEGES</b>			
	1. Colposcopy			

**PRIVILEGES NOT INCLUDED ON THIS FORM:** A request to perform any procedure or treatment not included on this form must be submitted to the Attending Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.

**TEMPORARY CLINICAL PRIVILEGES:** In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted as per the LAC+USC Attending Staff Association Bylaws.

Name: \_\_\_\_\_

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
			Competency	Other
Pediatrics-VIP				

### ACKNOWLEDGMENT OF PRACTITIONER:

I hereby certify that I have no physical or mental impairment which would interfere with my practice, and I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise in each group of procedures requested. I understand that in making this request I am bound by the LAC+USC Bylaws and/or policies of the hospital and medical staff.

\_\_\_\_\_  
 Applicant's Signature

\_\_\_\_\_  
 Date

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

\_\_\_\_\_  
 Supervising Physician (print)

\_\_\_\_\_  
 (Signature)

\_\_\_\_\_  
 Date

Name: \_\_\_\_\_

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
			Competency	Other
Pediatrics-VIP				

Department Chair/Chief/Designee recommendation:

**If there are any recommendations of privileges that need to be modified or have conditions added, indicate here:**

Privilege#: \_\_\_\_\_  
 Condition/Modification/Explanation: \_\_\_\_\_  
 \_\_\_\_\_

**If privileges are NOT recommended based on COMPETENCY, provide explanation:**

Privilege#: \_\_\_\_\_  
 Explanation for NOT recommending based on  
 COMPETENCY: \_\_\_\_\_  
 \_\_\_\_\_

If supplemental documentation provided, check here:

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I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

\_\_\_\_\_  
**SIGNATURE OF THE DEPARTMENT CHAIR/CHIEF/DESIGNEE**

\_\_\_\_\_  
**DATE**

APPROVED BY INTERDISCIPLINARY PRACTICE COMMITTEE ON:

APPROVED BY EXECUTIVE COMMITTEE ON:

APPROVED BY GOVERNING BODY ON:

PERIOD ENDING: